DELAWARE HEALTH AND SOCIAL SERVICES
Division of Long Term Care Residents Protection

DHSS - DLTCRP
3 Mill Road, Suite 308
Wilmington, Delaware 19806
(302) 421-7400

STATE SURVEY REPORT

NAME OF FACILITY: Millcroft Nursing Home

DATE SURVEY COMPLETED: March 31, 2021

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	The State Report incorporates by reference and also cites the findings specified in the Federal Report. An unannounced annual, and compliant survey was conducted at this facility from March 23, 2021, through March 31, 2021. The deficiencies contained in this report are based on observation, interviews, review of residents' clinical records and review of other facility documentation as indicated. The facility census the first day of the survey was forty seven (47) The survey sample totaled sixteen (16) Residents.		
3201	**Regulations for Skilled and Intermediate Care Facilities**		
3201.1.0	**Scope**		
3201.1.2	**Nursing facilities shall be subject to all applicable local, state and federal code requirements. The provisions of 42 CFR Ch. IV Part 483, Subpart B, requirements for Long Term Care Facilities, and any amendments or modifications thereto, are hereby adopted as the regulatory requirements for skilled and intermediate care nursing facilities in Delaware. Subpart B of Part 483 is hereby referred to, and made part of this Regulation, as if fully set out herein. All applicable code requirements of the State Fire Prevention Commission are hereby adopted and incorporated by reference.** **This requirement is not met as evidenced by:** Cross Refer to the CMS 2567-L survey completed March 31, 2021: F558 F574 F577 F585 F 641 F688 F812 F868 and F880.		
16 Del. C., 1162	**Nursing Staffing:**	**16 Del. C., 1162 - Nursing Staffing**	Completion Date: 5/17/21

Provider's Signature [signature] NHA Title Executive Director Date 5/4/2021

NAME OF FACILITY: Millcroft Nursing Home

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	(c) By January 1, 2002, the minimum staffing level for nursing services direct caregivers shall not be less than the staffing level re-quired to provide 3.28 hours of direct care per resident per day, subject to Commission recommendation and provided that funds have been appropriated for 3.28 hours of direct care per resident for Medicaid eligible reimbursement. **Nursing staff must be distributed in order to meet the following minimum weekly shift ratios:** **RN/LPN — CNA*** **Day — 1 nurse per 15 res. — 1 aide per 8 res.** **Evening — 1:23 — 1:10** **Night — 1:40 — 1:20** *** or RN, LPN, or NAIT serving as a CNA.** **(g) The time period for review and determining compliance with the staffing ratios under this chapter shall be one (1) week.** A desk review staffing audit was conducted by the State of Delaware, Division of Health Care Quality, Office of Long Term Care Residents Protection on April 2, 2021. The facility was found to be out of compliance with 16 Delaware Code Chapter 11 Nursing Facilities and Similar Facilities. Based on review of facility documentation it was determined that for one day out of 21 days, the facility failed to provide staffing at a level of at least 3.28 hours of direct care per resident per day (PPD). Findings include: Review of facility staffing worksheets, completed and signed by the Nursing Home Administrator,	**1162 Nursing Staffing** A. No immediate action could be taken to correct the previous failure to meet staffing requirements that was noted. When the alleged deficiency was identified, staffing assignments for the upcoming week were reviewed immediately and found to be in compliance. B. All residents have the potential to be affected by this alleged deficient practice. The DON, ADON, and nursing staff scheduler were immediately re-educated by the ED on the minimum shift ratios for nursing staff. The facility is currently using agency nursing staff as needed to supplement for any identified shortages to ensure PPD staffing requirements are met. C. A root cause analysis was done to determine that the cause of the alleged deficiency was multiple staff turnovers and callouts during that time period, paired with the lack of new applicants or utilization of agency nursing staff to fill staffing needs. The facility currently has positions posted for nursing staff and actively hiring new employees. Agency	

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	revealed the following: 1/02/2021 PPD = 2.8 3/31/2021 – E1(NHA) submitted an email to the state agency confirming a failure to meet staffing requirements. E21's email indicated the following "the information provided for 1/2/21 is accurate." The facility failed to maintain the minimum PPD staffing requirement of 3.28.	nursing staff is being utilized to fill staffing shortages as needed. Weekly staffing meetings will be held with either the ED, DON, or ADON and the nursing staff scheduler to review the upcoming schedules. On-call nursing is available at all times. All nursing schedules will be reviewed by the DON or designee prior to posting to ensure staffing requirements are met. D. ED will perform audits of the week's PPD sheet weekly x 4, twice a month x 4, and then monthly until 100% compliance is achieved. Results of audits will be submitted to the QAPI committee to determine the need for further submissions.	

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	085021	A. BUILDING _____ B. WING _____	C 03/31/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILLCROFT	255 POSSUM PARK ROAD NEWARK, DE 19711

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced annual and complaint survey was conducted at this facility beginning 3/23/21 through 3/31/21. The facility census the first day of the survey was 47. During this period, an Emergency Preparedness survey was also conducted by the State of Delaware Division of Health Care Quality, Office of Long Term Care Residents Protection in accordance with 42 CFR 483.73. For the Emergency Preparedness survey, no deficiencies were identified.	E 000		
F 000	INITIAL COMMENTS An unannounced annual, complaint, and emergency preparedness survey was conducted at this facility from 3/23/2021 through 3/31/2021. The deficiencies contained in this report are based on observations, interviews, review of clinical records and other facility documentation as indicated. The facility census the first day of the survey was forty seven (47). The survey sample size was 27. Abbreviations/definitions used in this report are as follows: ADON - Assistant Director of Nursing; CNA - Certified Nurse's Aide; DON - Director of Nursing; ED - Executive Director; LPN - Licensed Practical Nurse; NHA - Nursing Home Administrator; RN - Registered Nurse; RNAC - Registered Nurse Assessment Coordinator; UM - Unit Manager;	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		04/24/2021

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 000	Continued From page 1 AAROM - Active Assisted Range of Motion; BLE - Bilateral Lower Extremities; BUE - Bilateral Upper Extremities; Contracture - a condition of shortening and hardening of muscles, tendons, or other tissue, often leading to deformity and rigidity of joints; EHR - Electronic Health Record; EMAR - Electronic Medication Administration Record; FM - Family Member; Flaccid - limp or drooping; LUE - Left Upper Extremity; MDS (Minimum Data Set) - standardized assessment forms used in nursing homes; PPE- Personal Protective Equipment - equiment worn to prevent the spread of disease; Pressure Ulcers (PUs) - sore area of skin that develops when the blood supply to it is cut off due to pressure; coccyx - tail bone; Stage I - A pressure ulcer characterized by intact skin over a boney area that does not lighten to usual skin tone when pressed; PROM - Passive Range of Motion; ROM - Range of Motion; RUE - Right Upper Extremity;	F 000		
F 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by:	F 558		5/28/21

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F 558	Continued From page 2 Based on observation, interview and review of other documentation as indicated, it was determined that the facility failed to ensure reasonable accommodation of resident needs when R10's bedside table was set up along her left side preventing ability to access items on the bedside table due to R10's hand being splinted. Findings include: Review of R10's clinical record revealed: 12/29/2020- A care plan was created for being at risk for limitations in my ability to perform my ADL's related to a fracture (break) of the left hand with interventions to encourage the resident to participate to the fullest extent possible with each interaction. 1/3/2021- An admission MDS assessment documented R10 as requiring limited assistance with eating (how resident eats and drinks). During an interview on 3/24/2021 at 10:40 AM, FM3 was asked "Is the residents room set up to accommodate the residents needs?" to which FM3 responded, "all the furniture is on the other side, and the table is out of reach for R10, so R10 can't get anything off of it." 3/24/2021 PM 3:10 - R10 was observed in bed. R10's bed was positioned up against a wall on the right side with R10's bedside table along the left side. R10 confirmed being unable to reach items, the water cup and remote control, on the bedside table. During an interview on 3/25/2021 at 12:13 PM with E11(CNA), it was confirmed that R10 has limited use of the left hand, but is able to use the	F 558	F558: Reasonable Accommodations Needs/Preferences A. R10s room layout was immediately changed to allow resident access to bedside table with her Right hand the day the variance was identified, on 3/31/2021 B. All residents have the potential to be affected by this alleged deficient practice. All other residents' room layouts were evaluated on 4/1/2021 and 4/2/2021 to ensure appropriate accommodations were in placed based on residents' needs and preferences. C. A root cause analysis was done to determine that the cause of the alleged deficient practice was that when R10 was moved from her previous room to her current room her ability to reach her bedside table was not properly evaluated in the new room layout. ED/DON or designee will re-educate nurses and C.N.A.s on providing reasonable accommodations to residents and to verify that residents are positioned such that their accessibility to items in the room are not denied or limited. D. Weekly audits of 10% of residents will be completed by ED/DON or designee to verify that residents' needs and preferences are accommodated, verifying this both through resident interview and observation/resident demonstration. Audits will be done weekly for 4 weeks until 100% success is achieved. Results of audits will be submitted to the QAPI	

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F 558	Continued From page 3 right hand to drink and eat independently. E11 stated, "It depends on R10's energy, this morning R10 was able to feed herself, but this afternoon not as much, from tiredness...R10 uses the unsplinted hand." During an interview on 3/26/2021 at 1:55 PM, E10 (RN) was asked whether resident rooms are set up to accommodate resident needs. E10 stated, "Yes, by resident preference." During the same interview, E4 (OT) stated, "Sometimes it's us [therapy department] too, because it provides more space in the room for therapy or the line of sight for the TV is better. Or it assists them in accommodations for transfers like getting in the chair." E4 was then asked if R10's needs for accessibility due to restricted use of R10's left hand was assessed and factored in the placement of the bed and bedside table. E4 stated, "No, the room was always like that." E4 then looked at R10, confirmed the bedside table was not accessible for R10 and stated, "Anyone should always make sure items are in reach before leaving the room." These findings were reviewed during the exit conference on 3/31/2021 at 12:45 PM with E1 (ED) and E2 (DON).	F 558	committee monthly to determine the need for further submissions.	
F 574 SS=E	Required Notices and Contact Information CFR(s): 483.10(g)(4)(i)-(vi) §483.10(g)(4) The resident has the right to receive notices orally (meaning spoken) and in writing (including Braille) in a format and a language he or she understands, including: (i) Required notices as specified in this section. The facility must furnish to each resident a written description of legal rights which includes -	F 574		5/28/21

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F 574	Continued From page 4 (A) A description of the manner of protecting personal funds, under paragraph (f)(10) of this section; (B) A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment of resources under section 1924(c) of the Social Security Act. (C) A list of names, addresses (mailing and email), and telephone numbers of all pertinent State regulatory and informational agencies, resident advocacy groups such as the State Survey Agency, the State licensure office, the State Long-Term Care Ombudsman program, the protection and advocacy agency, adult protective services where state law provides for jurisdiction in long-term care facilities, the local contact agency for information about returning to the community and the Medicaid Fraud Control Unit; and (D) A statement that the resident may file a complaint with the State Survey Agency concerning any suspected violation of state or federal nursing facility regulations, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, non-compliance with the advance directives requirements and requests for information regarding returning to the community. (ii) Information and contact information for State and local advocacy organizations including but not limited to the State Survey Agency, the State Long-Term Care Ombudsman program (established under section 712 of the Older Americans Act of 1965, as amended 2016 (42 U.S.C. 3001 et seq) and the protection and advocacy system (as designated by the state, and as established under the Developmental	F 574		

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F 574	Continued From page 5 Disabilities Assistance and Bill of Rights Act of 2000 (42 U.S.C. 15001 et seq.) (iii) Information regarding Medicare and Medicaid eligibility and coverage; (iv) Contact information for the Aging and Disability Resource Center (established under Section 202(a)(20)(B)(iii) of the Older Americans Act); or other No Wrong Door Program; (v) Contact information for the Medicaid Fraud Control Unit; and (vi) Information and contact information for filing grievances or complaints concerning any suspected violation of state or federal nursing facility regulations, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, non-compliance with the advance directives requirements and requests for information regarding returning to the community. This REQUIREMENT is not met as evidenced by: Based on responses at the Resident Council Meeting, observations and interview, it was determined that the facility failed to post contact information for the State and local advocacy organizations including, but not limited to the State Survey Agency and the State Long-Term Care Ombudsman program. The facility also failed to post a statement that residents may file a complaint with the State Survey Agency concerning resident abuse, neglect and misappropriation of resident property in the facility. Findings include: On 3/25/2021 at 11:10 AM, during the Resident Council Meeting, in response to the question "Do residents know where the Ombudsman's information is posted?", six (R7, R13, R18, R24, R30, and R36) out of seven residents attending	F 574	F574: Required Notices and Contact Information. A. New signs were immediately added throughout the facility containing information about the Ombudsman program, the facility's assigned Ombudsman's name and phone number, the New Castle County Division of Long Term Care Residents Protection phone number, and the 24-hour phone number for Long-term Care Complaints. Residents R7, R13, R18, R24, R30, and R36 had this information reviewed with them and were notified of the location of the new signs on 4/1/2021. B. All residents have the potential to be	

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F 574	Continued From page 6 the meeting answered no. In response to the question, "Have residents been informed of their right (and been given information on how) to formally complain to the State about the care they are receiving?", six (R7, R13, R18, R24, R30, and R36) out of seven residents replied that they do not know where to find this information. They do not know the name of the Ombudsman, their role and the contact information. On 3/25/2021 at 3:15 PM, a tour of the Healthcare 1st and 2nd floors of the facility revealed the absence of complete postings of contact information for the State Survey Agency, posting of a statement regarding the filing of a complaint with the State Survey Agency, posting with information informing residents how to file a complaint with the State Agency, and posting with contact information for the Long Term Care Ombudsman. Observation on the 1st floor revealed no evidence of the Ombudsman contact information. Observation on the 2nd floor revealed no evidence of Nursing Home abuse hotline information. The facility failed to provide complete information on how to contact the State Agency, how to formally file a complaint to the State Agency and the Ombudsman's contact information, in areas accessible to all residents, visitors and staff. Findings were discussed with E2 (DON) on 3/25/2021 at 3:21 PM. Findings were reviewed with E1 (NHA), E2 and E3 (Interim NHA) at the Exit Conference on 3/31/2021 at 12:45 PM.	F 574	affected by this alleged deficient practice. Signs were hung in areas accessible to residents. Currently, no residents require language translation/brail, however should the need arise the facility has resources including but not limited to: The Delaware Department of Aging and Disability Resource Center, Para-Plus Translations, and Asta-USA. C. A root cause analysis was done to determine the cause of the alleged deficient practice to be that residents require more frequent reminders of the location of the contact information. ED/DON or designee to evaluate location of information posted for Ombudsman and the state agency periodically to ensure it is accessible to residents/families. At monthly Resident Council Meetings, ED/DON or designee will review notices and contact information for state and local advocacy organizations how to file a formal complaint to the state agency. Signs containing information about the Ombudsman program, the facility's assigned Ombudsman's name and phone number, the New Castle County Division of Long Term Care Residents Protection phone number, and the 24-hour phone number for Long-term Care Complaints were added to the following highly visible/high traffic areas: Health Care entrance across from the Dining Room (1st floor), outside of the Rehabilitation Gym (1st floor), the Activities Board (1st floor), the Nurses' Station (1st floor), the left wing hallway (1st floor), the right wing hallway (1st	

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F 574	Continued From page 7	F 574	floor), next to the elevator (2nd floor), the Activities Board (2nd floor), the Nurses' Station (2nd floor), the left wing hallway (2nd floor), and the right wing hallway (2nd floor). D. Weekly audits of 10% of residents will be completed by ED/DON or designee for 4 weeks to verify that residents are able to identify at least one location of the postings containing contact information for the state and local advocacy organizations and posting of how to file a formal complaint until 100% success is achieved. Results of audits will be submitted to the QAPI committee monthly to determine the need for further submission.	
F 577 SS=E	Right to Survey Results/Advocate Agency Info CFR(s): 483.10(g)(10)(11) §483.10(g)(10) The resident has the right to- (i) Examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility; and (ii) Receive information from agencies acting as client advocates, and be afforded the opportunity to contact these agencies. §483.10(g)(11) The facility must-- (i) Post in a place readily accessible to residents, and family members and legal representatives of residents, the results of the most recent survey of the facility. (ii) Have reports with respect to any surveys, certifications, and complaint investigations made respecting the facility during the 3 preceding	F 577		5/28/21

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F 577	Continued From page 8 years, and any plan of correction in effect with respect to the facility, available for any individual to review upon request; and (iii) Post notice of the availability of such reports in areas of the facility that are prominent and accessible to the public. (iv) The facility shall not make available identifying information about complainants or residents. This REQUIREMENT is not met as evidenced by: Based on interviews and observations, it was determined that the facility failed to post the most recent results of the State survey in a readily accessible area. Findings include: During the Resident Council meeting on 3/25/2021 at 11 AM, in response to the question, "Is the State inspection report available without having to ask?", residents who attended the meeting unanimously (seven out of seven residents) responded "no." 3/25/21 at 3:00 PM - An observation revealed that the facility's state survey report was located in the Healthcare entrance in the right corner of the lobby. Review of the reports indicated that the latest state survey result on file was dated July 23, 2019. Findings were confirmed by E2 (DON). The facility failed to post notice of the availability of the most recent results of the State survey in an area of the facility that was prominent so individuals wishing to examine the survey results were able to locate them easily and did not have to ask for them. Findings were reviewed with E1 (NHA), E2 (DON) and E3 (Interim NHA) during the Exit Conference on 3/31/2021 at 12:25 PM.	F 577	F577: Right to survey results/Advocate agency info. A. On 3/25/2021 the most recent survey was immediately placed in binder once it was noted to be missing. The location of the binder was moved from the previous location to a more visible area, directly across from the Healthcare Entrance. A sign was hung above the area stating the contents of the binder and the binder itself was clearly labeled. B. All residents have the potential to be affected by this alleged deficient practice. All completed surveys going forward will be immediately placed in the labeled survey binder located across from the Healthcare Entrance. Surveys since 7/23/2019 currently included in binder are State Survey from 9/15/2020, State Survey from 3/31/2021, and Fire Marshall/Life Safety survey from 4/5/2021. C. A root cause analysis was done to determine the cause to be administrative turnover in the past year causing the posting of survey updates to be	

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F 577	Continued From page 9	F 577	overlooked. ED/DON or designee will be responsible for immediately posting most recent state survey results in the designated binder to ensure it is accessible to all residents, family members, and legal representative of residents. Location of survey results to be reviewed at monthly Resident Council Meetings. The location of the survey results will also be printed in the facility's monthly newsletters published for residents and families (copies of this newsletter are emailed to all families). D. ED/DON or designee will perform audits of 10% of residents and at least 1 family member weekly for 4 weeks to verify that resident is aware of the location of the most recent state survey results until 100% success is achieved. Results of audits will be submitted to the QAPI committee to determine the need for further submissions.	
F 585 SS=E	Grievances CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay.	F 585		5/28/21

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F 585	Continued From page 10 §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. §483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident. §483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include: (i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system; (ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all	F 585		

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F 585	Continued From page 11 information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations; (iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated; (iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law; (v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance	F 585		

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F 585	Continued From page 12 decision. This REQUIREMENT is not met as evidenced by: Based on record review, interviews and review of other facility documentation as indicated, it was determined that the facility failed to ensure that grievances received by the facility included prompt efforts to resolve problems for one (R31) out of 16 residents sampled. In addition, the facility failed to ensure that a written decision was issued to the complainant. Findings include: Review of the facility's Complaints and Grievances policy, revised on 1/30/19 and effective 9/1/19 indicated: - Residents and their representatives, family members, or advocates have the right to make complaints or grievances without fear of reprisal or retribution from the community. The community's goal is to provide prompt investigation and resolution of all Complaints and Grievances. - A GRIEVANCE is a written complaint or verbal complaint that cannot be resolved promptly by the Executive Director or Administrator of the community. Additionally, the following circumstances (below) constitute a Grievance: a. Any complaint that is reduced to writing is considered a grievance. b. Whenever the resident, his/her representative, or family member requests that a complaint be handled as a formal grievance. c. OR when a written response is requested from the community then it is managed as a grievance. - The Executive Director/Administrator is responsible for the resolution of complaints and/or grievances, the maintenance of all documentation, including the complaint grievance report form, follow-up actions/ investigations, and	F 585	F585: Grievances. A. Immediate corrective action was not able to be taken regarding this alleged deficient practice. R31 is currently receiving indoor/outdoor visits from family. A meeting was held on 3/16/2021 with R31, her family, the ED, and the DON to address complaints and grievances. Follow-up on R31□s and family□s grievances, specifically regarding call lights, is ongoing. B. All residents have the potential to be affected by this alleged deficient practice. ED/Designee immediately began re-educating Departmental Managers, activities, rehabilitation, and nursing department staff 3/26/2021 on the facility□s grievance policy, completing a Grievance form. Additional Grievance Stations added with forms, officer contact information, and locked submission boxes have been added located directly across from Healthcare Entrance, and at 1st and 2nd floor Nurses□ Station. C. A root cause analysis was done to determine the cause of the alleged deficient practice to be turnover in administrative staff during past year causing inconsistent support needed to resolve all grievances. Current Grievance officers (ED, DON, and Social Worker) held meeting on 4/1/2021 discussed route cause, reviewed the grievance	

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F 585	Continued From page 13 updating the Concern/Grievance Log with details concerning the resolution. - A grievance is considered resolved when the resident or grievance is satisfied with the actions taken on his/her behalf. 1a. Review of the facility's Complaint/Grievance Log revealed: The Complaint/Grievance Log and a Complaint/Grievance Report were reviewed. Both reports documented that on 12/26/20 R31 voiced a complaint. The Grievance Log documented that the issues were resolved on 12/28/20, but the Grievance Report did not document evidence of resolution and agreement with the resident. The facility failed to have evidence that the complainant was informed of the findings of the investigation and that actions were taken to correct the identified problem(s). b. Review of the email correspondences regarding R31 between the facility and FM1 and FM2 (Family Members) revealed the following: 12/7/20 - FM2 emailed E4 (Activity Director) using FM1's email address regarding R31's outdoor visits. The facility lacked evidence that this email was recorded in the Complaint/Grievance Log and the facility lacked evidence that a Complaint/Grievance Report was completed with documented resolution and agreement with the complainant on file. 12/21/20 - FM1 emailed E3 (NHA) regarding R31 waiting for 45 minutes in the bathroom for toileting assistance from 8:00 PM to 8:45 PM on 12/21/20. The facility lacked evidence that this	F 585	policy/process, and the grievance log. Signs hung at first and second floor Nurses□ Stations naming Grievance Officers and their contact numbers. Re-education was done as stated in Section B. Facility□s grievance policy education continues to be conducted for all new employees. D. ED/DON or designee will perform weekly audits of grievances received to verify that grievances are handled per company policy. Resolved grievances will be verified through interview of complainant. Audits will be performed weekly for 4 weeks until 100% success is achieved. Results of audits will be submitted to the QAPI committee to determine the need for further submissions.	

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F 585	Continued From page 14 email was recorded in the Complaint/Grievance Log and the facility lacked evidence that a Complaint/Grievance Report was completed with a documented resolution and agreement with the complainant on file. 12/28/20 - FM2 sent a second email to E4 following up as he did not get a response from the facility regarding his concern from the first email on 12/7/20. The facility lacked evidence that this email was recorded in the Complaint/Grievance Log and the facility lacked evidence that a Complaint/Grievance Report was completed with documented resolution and agreement with the complainant on file. 1/3/21 - FM1 sent an email to E3 (NHA) and wanted it to be registered in the records as a formal complaint regarding unanswered call bells twice for over 45 minutes each time on 1/2/21. In the email, FM1 stated, " ...We never got any response to the previous complaint sent on 12/21/20." The facility lacked evidence that multiple emails from FM1 and FM2 with identified concerns were recorded in the Complaint/Grievance Log and the facility lacked evidence that Complaint/Grievance Reports were completed with documented resolutions and agreement with the complainants on file. 3/24/21 at 9:59 AM - In an interview, R31 stated that the call bell response service in the facility was not good especially during the past months, " ...I had to wait for 30-45 minutes to be assisted off the toilet. My family has reported this to the state. We did not hear anything from the management until we got the big boss in	F 585		

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F 585	Continued From page 15 corporate involved." 3/25/21 at 9:59 AM - In an interview, FM1 stated that there's still no significant changes in call bell response times. FM1 further stated that their numerous emails were left unanswered. FM1 added that she joined the meeting last week with the new management and is hopeful for progress and improvement. 3/25/21 at 3:35 PM - In an interview, E1 (NHA) stated that he initiated a grievance/concern report on 3/16/21 as a follow up to the initial complaint filed by the family last year. 3/25/21 at 3:40 PM - In an interview, E2 (DON) stated that he was aware of the issues of the family regarding staff's timeliness in answering call bells and stated that he was not directly communicating with the family regarding their grievances. 3/25/21 at 4:09 PM - In an interview, FM2 (Family Member) stated, "Mom's experience with (facility) as far as care and services specifically in attending to her call bells was very bad and the management's response was very unacceptable, very dismissive with our appeal and not responsive to us in addressing our emails. I had to go through Corporate and let them know." 3/29/21 at 10:00 AM - In an interview, E5 (SW, Grievance Officer) confirmed that R31 only had one filed grievance report on 12/26/20; it was recorded in the grievance log as well. 3/31/21 at 2:06 PM - When asked how the facility was handling the concerns raised by FM1 and FM2 via email, E3 documented, " ...If I did not	F 585		

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F 585	Continued From page 16 respond via email then I pick up the phone." 3/30/21 at 1:35 PM - A social worker progress note, dated 11/9/20, documented that an IDT (Interdisciplinary Team) meeting was done on 11/9/20 with R31, FM1 and FM2 in attendance to discuss care and services. It was also documented that a follow up meeting was to be scheduled within the next 30 days to discuss progress made on improving the current status of certain areas of care. 3/30/21 at 1:40 PM - When asked by the surveyor what R31's certain areas of care concerns were about and if the meeting with R31 and her family was done in December 2020, E5 (SW, Grievance Officer) stated that the family was concerned about staff and delayed call bell response times. E5 further confirmed that the follow up meeting scheduled to take place in December 2020 did not happen. When asked why the meeting did not proceed as scheduled, E5 stated, " There were changes in the management and necessary members of the management team were not available. It was hard to complete the IDT team to hold a meeting with the family." When asked if the family was notified, E5 replied, "No." When asked why the family was not notified of any status updates, E5 stated, "I don't know. I don't see anything in the progress notes indicated here, but the nursing department makes frequent communication with the family." 3/30/21 at 2:00 PM - In a telephone conference, E3 (Interim NHA) said that she had a conversation with FM2 to schedule a meeting online via Zoom in December 2020 when facility visits were restricted. E3 further stated that FM2	F 585		

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F 585	Continued From page 17 refused to attend unless the meeting was be done in person. 3/31/21 at 2:06 PM - In an email, the Surveyor asked E3 if the facility made another attempt to reschedule the meeting and E3 replied, "...FM2 asked to speak with my supervisor and would only speak with her. During their conversation, he agreed to wait for a new ED (Executive Director/ NHA) once he was onboard and acclimated." R31 and her family were scheduled for a follow up meeting after 11/9/2020, however, the actual meeting took place on 3/16/2021. The facility failed to make prompt efforts to resolve FM1 and FM2's complaints and grievances and to keep R31 and the family appropriately and promptly notified of progress towards resolution. 3/30/21 at 2:00 PM - Findings were discussed with E1 (NHA), E2 (DON) and E3 (Interim NHA).	F 585		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on clinical record reviews and interviews, it was determined that for two (R10 and R40) out of 16 sampled residents reviewed for MDS assessments, the facility failed to accurately reflect each residents' status. Findings include: 1. Review of R40's clinical record revealed: 3/10/2021 - The quarterly MDS assessment	F 641	F641: Accuracy of Assessments. A. Based on review of medical records for residents R40 and R10, MDS coding inaccuracies did not negatively impact or cause harm to either resident identified. MDS modifications were immediately completed for both assessments. The modified assessments were submitted	5/28/21

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F 641	Continued From page 18 documented that R40 did not have a condition or chronic disease that may result in a life expectancy of less than six months. R40's clinical record documented that R40 was receiving hospice services at the time of the 3/10/2021 MDS assessment for a chronic disease that may result in a life expectancy of less than six months. The facility failed to accurately reflect R40's prognosis on the 3/10/2021 quarterly MDS assessment. 3/31/2021 at 10:23 AM - During an interview in the presence of E1 (NHA), E2 (DON) and E9 (RCM), E8 (MDS Coordinator) confirmed the finding. 2. Review of R10's clinical record revealed the following: 12/28/2020 - R10 was admitted to the facility. 12/28/2020 - A skin and wound total body skin assessment documented "New wounds 1." 12/29/2020 11:11 AM- A skin/wound note documented, "admitted last evening... Skin assessment completed stage 1 pressure injury identified to the coccyx...". 1/3/2021- An admission MDS assessment documented that R10 had a pressure ulcer, was at risk for pressure ulcers, but had no unhealed pressure ulcers and the pressure ulcer staging section was left blank for each stage. During an interview on 3/31/2021 at 10:11 AM, in the presence of E1 (ED) and E2 (DON), E8 (MDS coordinator) was asked to review the accuracy of	F 641	and accepted into QIES on 3/31/2021. R40 was receiving Hospice services and continued to do so based on the presence of a condition or chronic disease that may result in a life expectancy of less than six months. The miscoding of the MDS did not affect the care and services being provided to the resident. With regards to R10, direct care staff were aware of the skin condition identified upon admission to the facility and complied with the recommended interventions to address the Stage 1 pressure injury to the coccyx. B. All residents have the potential to be affected by this alleged deficient practice. The Interim MDSC, a consultant from an agency, was immediately re-educated on 3/31/2021 regarding the importance of accuracy when completing MDS Assessments. It is the policy of the facility to accurately complete MDS Assessments in order to reflect the resident's condition and status at time of Assessment Reference Date (ARD) as per the RAI Manual. C. A root cause analysis was done to determine that the coding errors identified were a data entry error. As previously stated the Interim MDSC, a consultant from an agency, was immediately re-educated by the Case Manager assigned to oversee the building and the owner of the contract company regarding the importance of accuracy when completing MDS Assessments to ensure that the document accurately reflects the residents condition and status at the time	

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F 641	Continued From page 19 R10's 1/3/2021 MDS assessment. E8 stated the MDS was "Accurate based on the information I had at the time." During the same interview, E2 confirmed that R10 was admitted with a Stage I pressure ulcer. These findings were reviewed during the exit conference on 3/31/2021 at 12:45 PM with E1 (ED) and E2 (DON).	F 641	of the ARD and that the assessment is completed in accordance with the coding rules as specified in the RAI Manual. MDS consultant expressed understanding. D. The MDS Consultants supervisor or a designee will perform audits of 100% of MDS assessments completed during the calendar week in order to confirm accuracy of coding. Audits will be completed weekly for 2 months commencing the week of 4/19/2021 or until 100% compliance achieved, then monthly until an error rate of zero is attained. Any negative variances will be corrected immediately at the time at which it is identified. A report indicating the results of the observations will be provided to the Administrator and results of audits will be submitted to the QAPI committee to determine the need for further submissions.	
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion.	F 688		5/28/21

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F 688	Continued From page 20 §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to provide appropriate treatment and services to increase range of motion (ROM) and/or to prevent further decrease in ROM for one (R39) out of three residents sampled for ROM limitations. Findings include: Review of R39's clinical record revealed: 9/1/2016 - R39 was admitted to the facility with left sided weakness and paralysis. 3/22/2018 - The Interdisciplinary Rehabilitation Screening Form documented that R39 was seen for an Annual Screen and no functional change was noted 10/11/2018 - Review of the Occupational Therapy (OT) Plan of Care documented R39's Initial Assessment which stated LUE (Left Upper Extremity) appears to be flaccid. RUE (Right Upper Extremity) shoulder flexion 70 degrees, elbow 20 degrees, and cervical neck 10 degrees. 12/26/2018 - A care plan for being at risk for contractures was reviewed, R39 has contractures of the neck with head tilted towards the right and shoulder and flaccid LUE per visual inspection and RN assessment. The goal was that R39 would not have new contractures. Interventions	F 688	F688 SS=D Increase/Prevent Decrease in ROM/Mobility A. R39 was screened by rehab on 4/7/2021 and status for all ROM in all extremities was documented. B. All other long-term care residents were screened by the therapy department and found to not have been affected by the alleged deficient practice. Therapy team reviewed company's policies and procedures regarding screening of long-term care residents. C. A root cause analysis was done to determine that the cause of the alleged deficient practice was that R39 was placed on hospice for an extended period of time and when she was taken off hospice care she was not added back into rehabilitation's cue correctly. At the start of every month the MDS Coordinator will provide the Rehabilitation Department a list of community residents scheduled for a quarterly or annual MDS assessment that month. The Therapy Team Leader (TTL) or designee will verify this list and all residents contained on the list will be screened by the TTL or designee. ROM status will be documented to verify there has been no decline in ROM. The	

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F 688	Continued From page 21 included: Perform AAROM to RUE and PROM to BLE BID x 15 minutes. 3/4/2019 through 3/9/2021 - Review of all the MDS Assessments during this period of time documented ROM limitation of the upper and lower extremities on one side of the body. 9/2020 through 3/25/2021 - Review of the CNA documentation revealed that AAROM to RUE and PROM to BLE was completed twice a day for 15 minutes. There was lack of evidence that the facility had a system to ensure R39's ROM was reassessed since discharge from OT on 10/15/2018. This failure resulted in the facility's inability to determine the status of her ROM. 3/23/2021 2:30 PM - R39 was observed in bed independently drinking fluids using her right hand. R39 verbalized that she cannot use her left arm and leg due to a previous stroke. 3/25/2021 9:45 AM - An interview with E6 (LPN UM) revealed that R39 had a left hand splint in the past, but refused to wear it , thus, it was discontinued. 3/25/2021 3 PM - An interview with E14 (Director of Rehabilitation Services) revealed that he recalled the facility was conducting annual ROM/contracture measurements previously and he will be speaking with his supervisor and follow-up with the Surveyor. E14 confirmed no further assessments have been completed since discharge from OT on 10/15/2018 by the Rehabilitation Department.	F 688	residents will be assessed for the need for skilled intervention to update plan of care interventions when ROM changes are noted. D. TTL or designee will perform audits of all long-term care residents on the monthly resident list provided by the MDS Coordinator to verify their screening/assessment was completed to ensure ongoing monitoring of ROM status for all long-term care residents in the community. Audits will be conducted at the end of the month until 100% compliance is met. Results of audits will be submitted to the QAPI committee to determine the need for further submissions.	

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	085021	A. BUILDING _____ B. WING _____	C 03/31/2021

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F 688	Continued From page 22 3/30/21 2 PM - An interview with E15 (Regional Director of Rehabilitation Services) confirmed that since R39's discharge from OT on 10/15/2018, no further ROM screens or assessments has been completed by the Rehabilitation Department. On a going forward basis, E15 stated that a system will be established to ensure periodic screening or assessment of ROM by the Rehabilitation Department. 3/31/2021 12:45 PM - Findings were reviewed with E1 (ED) and E2 (DON) during the Exit Conference.	F 688		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of	F 812	Food Procurement, Store/Prepare/Serve-	5/28/21

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F 812	Continued From page 23 facility documents, it was determined that the facility failed to monitor food temperatures in accordance with professional standards for food safety for cooking/reheating, covering food items, maintaining proper refrigerator temperatures, and ensuring the appropriate strength of sanitizing solution. Findings include: 1. 3/23/2021 9:48 AM - During the Initial Kitchen tour, a plastic container of lettuce was uncovered, two large cuts of cooked meat were left on lower racks partially uncovered, and containers of cooked vegetables were observed uncovered on a work surface area. 3/23/2021 12:42 PM - Interview with E19 (Food Service Director) and E1(NHA) confirmed the uncovered food and the potential safety hazards associated with it. 2. 3/23/2021 10:10 AM - During a kitchen tour, the sanitizing solution in a red sanitizer bucket was tested for chemical concentration by E19 (Food Service Director). The chemical concentration reading was too low and did not register at a sanitizing level on the test strip. The ineffective level of sanitizing agent was confirmed by E19 at 10:15 AM. 3/23/2021 12:42 PM - Interview with E19 (Food Service Director) and E1 (NHA) confirmed the inadequate sanitizer level. 3. 3/23/2021 11:25 AM - The surveyor observed numerous days of temperature log entries were missing from the past six months of recorded logs. Temperatures of cooked foods were not consistently recorded prior to being served. Fish, meat and poultry must be heated to an	F 812	Sanitary 1. Uncovered food during Initial Kitchen tour. A. Uncovered lettuce was immediately discarded, the meat that had been freshly cooked was covered immediately, cooked vegetables in pan on work surface were part of work in progress and immediately covered until ready for use. B. All residents have the potential to be impacted by this alleged deficient practice. Cooks present in kitchen at the time were immediately re-educated 3/23/2021 on the importance of covering food by FSD. C. A root cause analysis was done to determine that the lettuce was improperly covered with plastic wrap. The meat and mixed vegetables were not covered immediately after cooking as required. Food Service Director (FSD) or designee will re-educate Cooks and Dietary Aids on the importance of covering food and food safety. D. FSD or designee will perform audits to ensure all food is properly covered daily x 2 weeks, then weekly x 2 weeks until 100% compliance is met. Results of audits will be submitted to the QAPI committee to determine the need for further submissions. 2. Low chemical concentration in red sanitizer bucket during kitchen tour. A. The solution in the red sanitizer bucket was immediately discarded. The bucket was refilled and tested at correct sanitation parts per million (PPM). B. All residents have the potential to be	

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F 812	Continued From page 24 appropriate temperature depending on the method used and type of food. Vegetables must be heated to 135 degrees Fahrenheit (F). 3/23/2021 1:25 PM - E19 [FSD] confirmed that food temperatures had not been consistently taken and recorded and entries were, "sporadic at best." 4. 3/23/2021 10:07 AM - The temperature of the "four door reach through" refrigerator was: 44.6 degrees Fahrenheit (F) 10:24 AM - The temperature was 48. 2 degrees F. 11:32 AM - the temperature was 49.3 degrees F. 11:47 AM - the temperature of the refrigerator was 45.1 degrees F. 3/23/2021 1:35 PM - Interview with E19 (Food Service Director) and E1 (NHA) confirmed awareness of the temperatures and the food safety concerns related to cold holding temperatures above 41 degrees F.	F 812	impacted by this alleged deficient practice. FSD immediately re-educated Cooks and Utility staff to ensure concentration reading in sanitizing solution is correct PPM. C. A root cause analysis was done to determine that since sanitizing solution PPM breaks down/weakens over time, the solution should have been replaced sooner. FSD will re-educate Cooks and Utility staff on the process and importance of maintaining correct PPM in sanitizer solution. Sanitizer solution will continue to be tested and documented 3 times a day. D. FSD or designee will test sanitation solution in red buckets to verify appropriate PPM every day x 2 weeks, then weekly x 2 weeks until 100% compliance. Results of testing will be submitted to the QAPI committee to determine the need for further submissions. 3. Temperature of cooked food was not consistently recorded prior to being served. A. Food temperature was tested immediately when alleged deficiency was identified and food at that time was in appropriate temperature range. B. All residents have the potential to be impacted by this alleged deficient practice. Cooks and Dietary Aids on duty were immediately re-educated on importance of food temperature and food safety by FSD. C. A root cause analysis and staff interviews were done to determine that food temperatures were being obtained but not being documented. A new	

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F 812	Continued From page 25	F 812	temperature log was created and Cooks and Dietary Aids will be in-serviced on the new log and re-educated on the importance of taking and recording food temperatures. D. FSD or designee will audit the food temperature log to ensure that food temperatures are being obtained and recorded appropriately every day x 2 weeks, then weekly x 2 weeks until 100% compliance. Results of audits will be submitted to the QAPI committee to determine the need for further submissions. 4. Temperature of 'four door reach through refrigerator' reading 44.6-49.3 degrees F. A. JMS Services was immediately called to service the refrigerator unit. All the food in the unit had temperatures obtained and all were found to be in safe range. All food was then moved from the four door refrigerator to the walk-in refrigerator. B. All residents have the potential to be affected by this alleged deficient practice. The four door refrigerator was fixed on 3/23/2021 and continues to be in working order. C. The root cause of the temperature abnormalities was due to a leak in the coils per JMS Services. There was no measure that could have been taken by kitchen staff to prevent this per JMS Services. FSD or designee will continue to schedule preventative maintenance and inspection of units every 6 months. D. FSD or designee will audit the	

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F 812	Continued From page 26	F 812	temperatures of the refrigeration units to verify correct temperatures every day x weeks, then every week x 2 weeks until 100% compliance is met. Results of testing will be submitted to the QAPI committee to determine the need for further submissions.	
F 868 SS=F	QAA Committee CFR(s): 483.75(g)(1)(i)-(iii)(2)(i) §483.75(g) Quality assessment and assurance. §483.75(g)(1) A facility must maintain a quality assessment and assurance committee consisting at a minimum of: (i) The director of nursing services; (ii) The Medical Director or his/her designee; (iii) At least three other members of the facility's staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role; §483.75(g)(2) The quality assessment and assurance committee must: (i) Meet at least quarterly and as needed to identifying issues with respect to which quality assessment and assurance activities are necessary. This REQUIREMENT is not met as evidenced by: Based on interview and review of facility documentation as indicated, it was determined that the facility failed to ensure that the quality assessment and assurance committee (QAA) meet at least quarterly to identify issues with respect to which quality assessment and assurance activities. The facility also failed to ensure the QAA committee included a Medical Director or designee. Findings include:	F 868	F868 QAA Committee A. QAPI committee members were immediately updated to include Medical Director on 3/31/2021. QAPI meeting was held on 4/19/2021 to discuss State Survey, with required attendees present. Quarterly meeting scheduled 4/29/2021.	5/28/21

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F 868	Continued From page 27 3/29/2021 3:25 PM - A review of the facility provided list of QAA committee members and the facility QAPI (quality assurance and performance improvement) plan revealed the absence of a Medical Director or designee as part of the QAA committee. During an interview on 3/31/2021 at 12:12 PM with E1 (ED) and E2 (DON), it was confirmed that the facility Medical Director was not a QAA committee member. It was also revealed that the facility lacked evidence of quarterly assessment meetings dating back to the previous annual recertification date of 3/22/2019. These findings were reviewed during the exit conference on 3/31/2021 at 12:45 PM with E1(ED) and E2 (DON).	F 868	B. Quality assurance and all residents have the potential to be affected by this alleged deficient practice. Quarterly QAPI meetings have been scheduled, with additional meetings to be scheduled on an as needed basis. C. A root cause analysis was done to determine the cause of the alleged deficient practice to be difficulty holding meetings during the pandemic, as well as turnover in administrative staff during this time leaving the current administrative staff unable to locate previous QAPI records. The ED/DON will hold at minimum quarterly meetings of the quality assessment and assurance committee (QAPI) with attendees including but not limited to: the ED, the DON, the Medical Director, and at least three other staff members. A QAPI binder has been created to hold all meeting minutes and attendance records, and has been placed in the central location of the administrative office. D. The ED or designee will audit quarterly QAPI meetings to ensure the ED, DON, the Medical Director, and at least three other staff members are in attendance x 4 until 100% compliance achieved.	
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and	F 880		5/28/21

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F 880	Continued From page 28 comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the	F 880		

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F 880	Continued From page 29 circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, CDC (Centers for Disease Control and Prevention) guidance and other documentation as indicated, it was determined that the facility failed to follow CDC recommendations to prevent the spread of COVID-19 when residents were observed without facemask's or cloth face coverings outside of their rooms and when the room of a resident on droplet precautions did not have signage to indicate the type of precautions and required PPE for entry. Findings include: 1. 3/29/2021 (updated) - The CDC guidance for "Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019	F 880	F880: Infection Prevention and Control. 1. "Residents observed without face masks or cloth face coverings while outside of their room." A. Residents were immediately re-directed/assisted with mask placement when deficiency was identified. Nursing staff on affected unit were immediately re-educated on redirecting and assisting residents with mask placement. R45 and R200 continue to be free of any signs/symptoms of respiratory illness with no positive residents or staff on routine COVID-19 testing conducted the week of	

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F 880	Continued From page 30 (COVID-19) Pandemic" included, "Implement Universal Source Control Measures. Source control refers to use of cloth face coverings or facemask's to cover a person's mouth and nose to prevent spread of respiratory secretions when they are talking, sneezing, or coughing ...Because of the potential for asymptomatic (showing no symptoms) and pre-symptomatic transmission, source control measures are recommended for everyone in a healthcare facility, even if they do not have symptoms of COVID-19. ...Patients may remove their cloth face covering when in their rooms but should put it back on when around others (e.g., when visitors enter their room) or leaving their room. Facemask's and cloth face coverings should not be placed on young children under age 2, anyone who has trouble breathing, or anyone who is unconscious, incapacitated or otherwise unable to remove the mask without assistance." (https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care.html?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Fcoronavirus%2F2019-ncov%2Fhcp%2Fnursing-homes-responding.html) 3/23/2021- The following observations occurred: 9:49 AM - 9:55 AM - R200 was observed seated across from the nurses station without a facemask or cloth covering and was not reminded to wear a mask or offered a mask by facility staff. 9:56 AM - E10 (RN) offered R200 a face mask and assisted with placement. 9:58 AM - R200 removed the facemask. 1:29 PM - R200 was observed seated in the hall across from the nurses station without a facemask or cloth face covering. 3/29/2021- The following observations occurred:	F 880	4/12/2021. R33 was discharged from facility 4/8/2021 also without signs/symptoms of respiratory illness or related incidents prior to discharge. B. All residents have the potential to be affected by this alleged deficient practice. All healthcare personnel responsible for providing direct patient care including nursing, activities staff, and rehabilitation therapists, will be re-educated regarding the use of face masks/coverings when residents are out of their rooms by the Staff Development Coordinator (SDC) by 5/17/2021. C. After a root cause analysis was conducted the cause was determined to be the cognitive impairments in the sample group and lack of constant reminders from staff. All residents will have masks available to them at all times when out of their rooms. They will be consistently reminded by staff to wear their masks, and be assisted with proper placement as needed. Signs using large print and photographs were placed at 1st and 2nd floor Nurses' Station as a visual reminder to residents to wear their masks. Health care personnel will continue to maintain social distancing of CDC's recommended 6 feet among residents when not in their rooms. Nursing staff will continue screening residents for symptoms of COVID-19, and monitoring temperature, respiratory rate, and pulse ox every shift. D. Nursing supervisor or designee will observe residents seated at the 1st floor Nurses' Station for mask compliance every shift x 3 days, daily x 3 days, and	

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F 880	Continued From page 31 1:36 PM -1:46 PM - R200 was observed seated across from the nurses station with no facemask or cloth covering. 1:36 PM- 2:10 PM - R33 was observed seated across the nurses station without a facemask or cloth covering. 1:41 PM -1:42 PM - E12 (CNA) assisted R33 with a puzzle, and gave no redirection for R33 to put on a facemask. E12 then walked past R200 without redirecting the resident to wear a facemask. 1:42 PM - E13 (LPN) educated R200 on the importance of wearing a facemask and assisted R200 with placement of a face mask. R200 removed the mask once E13 was no longer facing the resident. E13 did not redirect, educate or assist R33 who continued to do the puzzle without a facemask, seated across from the nurses station. 1:43 PM - E10 (RN) walked past R33 and R200 and did not ask the residents to wear a facemask. 1:44 PM - E12 (CNA) walked past R33 and R200 and gave no reminder to put on a mask. 1:46 PM - E13 (LPN) replaced R200's mask. 2:10 PM- R33 still doing puzzle seated across from the nurses station with no facemask or cloth covering, and no redirection from staff. 3/30/21 The following observations occurred: 9:22 AM - 9:28 AM - R33, R45 and R200 were observed seated across from the nurses station without facemask's or cloth coverings. During an interview on 3/30/21 at 9:29, AM E10 (RN) confirmed that R33, R45 and R200 were seated across from the nurses station without face coverings.	F 880	weekly x 3 weeks until 100% compliance is met. Observation will be done one month later to ensure that 100% compliance is being maintained. 100% compliance will be defined as residents wearing masks at all times and/or consistently being reminded to by health care staff while maintaining social distancing from other residents. Results of audits will be submitted to the QAPI committee to determine the need for further submissions. 2. "The room of a resident on droplet precautions did not have signage to indicate the type of precautions and required PPE for entry." A. On 3/23/22021 when R201'S room was checked by Staff Development Coordinator (SDC), droplet precautions sign a PPE cart was already in place at the entrance to the room. B. All residents have the potential to be affected by this alleged deficient practice. On 3/23/2021 the SDC and Unit Manager ensured that all residents with ordered transmission based precautions had appropriate signage in place. C. After a root cause analysis was conducted the cause was determined to be the additional signage, other than the required Precautions/PPE signage, outside of residents' rooms may be confusing to staff and visitors causing them to miss seeing the required isolation signage. Required isolation signage recommended by CDC will be placed outside of all residents' rooms on isolation	

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F 880	Continued From page 32 2. Review of R201's clinical record revealed: 3/15/2021- R201 was admitted to the facility. 3/1520/21 10:31 PM - A progress note documented, "Resident on droplet precautions for 14 days per facility protocol." A random observation on 3/23/2021 at 10:10 AM revealed the absence of signage outside of room 118 B to indicate that the resident was on droplet precautions and what type of PPE was required to be worn for entry. 3/23/2021 at 11:21 AM - During an interview, E10 (RN) and the first floor unit manager confirmed the absence of signage outside of the room. These findings were reviewed during the exit conference on 3/31/2021 at 12:45 PM with E1 (ED) and E2 (DON).	F 880	with excessive non-essential signage eliminated. SDC will educate nursing staff on hanging appropriate CDC precaution signage outside of residents' rooms requiring isolation. D. Nursing Supervisor or designee will check residents' rooms requiring isolation to verify correct precautions signage is in place daily x 3 days, then weekly x 3 weeks until 100% compliance is met. Observation will be done one month later to ensure that 100% compliance is being maintained. Results of audits will be submitted to the QAPI committee to determine the need for further submissions.	